Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910977	A. BUILDING: _____ B. WING _____	R 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS MERCEDES BOARDING HOME	3418 SW 23RD TERRACE MIAMI, FL 33145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A complaint Survey (complaint number 2020000041) 2nd revisit was conducted at Las Mercedes Boarding Home on & . . . . Deficiencies were identified at the time of survey.	{A 000}		
{A 032} SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	{A 032}		

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{A 032}	Continued From page 1 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy and procedures regarding elopement and failed to conduct any elopement drills within a year period. Findings included:	{A 032}		

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{A 032}	Continued From page 2 Review of the facility's records showed the facility completed elopement drills on , , and . On at 12:54 PM, Staff A stated that the facility did not complete any elopement drills for the current year (2020). He added that health assessments did not identify any resident as risk for elopement. Uncorrected Class III	{A 032}		
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or	{A 162}		

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{A 162}	Continued From page 3	{A 162}		

implemented by the facility that require a health care provider's order.
(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.
(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.
(f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually.
(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.
(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form

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{A 162}	Continued From page 4 Alternate Care Certification for ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the	{A 162}		

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{A 162}	Continued From page 5 facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have documentation of the existence of a Power of Attorney (POA) for one out of 20 sampled residents (Resident #4). Furthermore, the facility failed to have any documentation of a semi-annual record for four out of 20 sampled residents (Residents #3, #4, #5 and #18) who needed assistance with activities of daily living. Findings included: 1) A review of Resident #4's records showed her admission date was on and that the resident's daughter signed the admission package. Further review of Resident #4's records showed no evidence of any POA document that showed Resident #4's daughter is her POA. On at 12:40 PM Staff A stated, "but, Resident #4 was competent. Oh, her daughter signed for her. I did not know. The POA is not there?	{A 162}		

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{A 162}	Continued From page 6	{A 162}		

2) Review of Resident #3's records showed her admission date was on and had no documentation of a chart. The health assessment was completed on and showed diagnoses of type II, failure, dependence of . Furthermore, she needed assistance in ambulation, bathing, , self-care, toileting and transferring and assistance with self-administration of medication.

Review of Resident #4's records showed her admission date was on and there was no documentation of her semi-annual record. The health assessment was completed on and showed diagnoses and medical history of , uncomplicated, primary generalized (osteo) , sleep , major , single episode, mild, state, of -protein metabolism, NEC ( ), of , on right heel. She needed assistance in all activities of daily living (eating, ambulation, bathing, , self-care, toileting and transferring) and with self-administration of medication.

Review of Resident #5's record showed her admission date was on and had no documentation of a semi-annual record. The health assessment was completed on and showed diagnoses and medical history of type 2 with other in phase, essential primary , age-related decline,

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{A 162}	Continued From page 7 failure, [illegible], unspecified. Furthermore, she needed total care in all activities of daily living (eating, ambulation, bathing, [illegible], self-care, toileting and transferring). Review of Resident #18's showed his admission date was on [illegible] and had no documentation of a semi-annual [illegible] record. The health assessment was completed on [illegible] and showed diagnoses and medical history of [illegible], essential primary [illegible], type 2 [illegible] without complications, [illegible] prostatic hyperplasia without lower [illegible] tract symptom, primary generalized (osteo) [illegible], major [illegible], slow transit [illegible], lower [illegible]. He was independent in eating, however, he needed assistance in ambulation, bathing, [illegible], self-care, toileting, transferring and with self-administration of medication. On [illegible] at 12:40 PM, Staff A acknowledged the records were incomplete. Uncorrected Class III	{A 162}		